



The City of New York
Department of Investigation

ROSE GILL HEARN
COMMISSIONER

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February 27, 2012

Commissioner Robert LiMandri
New York City Department of Buildings
280 Broadway
New York, New York 10007

Re: 285 Madison Avenue, NY, NY
Fatal Elevator Incident

Dear Commissioner LiMandri:

The New York City Department of Investigation ("DOI") recently completed an investigation conducted in conjunction with the New York City Department of Buildings ("DOB") relating to the fatal elevator incident that occurred on December 14, 2011 at 285 Madison Avenue in Manhattan.¹

The information discussed below details the investigative findings regarding the facts and circumstances relating to the fatal elevator incident.

I. Introduction

On December 14, 2011, at approximately 9:56 a.m., a fatal elevator incident occurred at 285 Madison Avenue, Manhattan. At that time, Suzanne Hart, a 41-year old employee at Y&R (formerly Young & Rubicam) who worked at the building, attempted to enter elevator number 9, which was stationary in the lobby with two passengers inside, and its doors fully open.² Just as Hart entered the elevator cab's doorway, the elevator accelerated upwards while its doors were still open. The moving elevator struck Hart at approximately knee level causing her to fall forward into the elevator cab. The

¹ During the course of the investigation, DOB retained the consultant Lerch Bates, Inc. to assist in the forensic investigation of the cause of the fatal elevator incident. In addition to DOI and DOB, the New York City Police Department ("NYPD") and the federal Occupational Safety & Health Administration ("OSHA") also participated in aspects of the investigation.

² 285 Madison Avenue is a 27-story building that was built in 1926. The elevator system in the building consists of a high-rise bank of six elevators (#s 1-6) and a low-rise bank of six elevators (#s 7-12). The low-rise bank of elevators services floors 1-12 with the high-rise bank of elevators serving floors 13-25.

elevator cab continued to move upward, trapping Hart between the elevator door saddle and the hoist way wall. The elevator cab came to a stop approximately 20 feet above the lobby landing sill. Hart subsequently died of her injuries at the scene of the incident.

On the morning of the incident, seven employees of Transel Elevator, Inc. (“Transel”) were present at 285 Madison Avenue to work on the low-rise bank of elevators, including the number 9 elevator.³ Transel mechanics worked on elevator number 9 from approximately 9:25 a.m. until several minutes before the incident occurred.

Following the incident, DOI and DOB jointly reviewed camera footage from 285 Madison Avenue and conducted initial interviews of the Transel employees at the scene of the fatality. Those Transel employees were subsequently re-interviewed at DOI under oath. DOI and DOB also interviewed John Fichera, Transel’s owner and a DOB-licensed Private Agency Elevator Director, who was not present at 285 Madison Avenue at the time of the incident. In addition, DOB commenced a post-incident inspection and forensic examination of elevator number 9.

II. Review of Security Camera Video from 285 Madison Avenue

DOI reviewed numerous hours of video footage recorded at 285 Madison Avenue on December 14, 2011.⁴ Specifically, DOI’s review focused on the time period of 5:09 a.m., when Transel workers first arrived at the building, through 9:56:50 a.m., when Ms. Hart was fatally struck by elevator number 9. Below is a timeline of relevant video footage viewed with the approximate times and includes details from relevant witness testimony provided to DOI:

5:09 a.m.: Transel employees, Andrea Cammisuli and Thomas Moran arrived at 285 Madison Avenue. On the day of the incident, Cammisuli and Moran were working as “Adjusters” assigned to replace the 14th floor elevator control panel computer chips, also known as EPROMs.⁵

7:12 a.m.: Transel Mechanic Efrain Cardona and Apprentice-Helper Jason Torzilli arrived at 285 Madison Avenue. Cardona and Torzilli were part of a Transel team who were to perform a governor recalibration of the low-rise elevators. The purpose of this recalibration was to modify the governor tripping speed so that the elevator would travel at a lower speed.

³ Transel had been hired by Cushman & Wakefield, the building management company, to perform upgrade work for the building under DOB filing EBN 1328/11. According to EBN 1328/11, the description of the work to be performed was “reduce car speed from 600 FPM (Feet Per Minute) to 500 FPM” for the low-rise elevator bank cars. This upgrade was required to ensure that the building would pass the NYC Building Code category 5 safety test. John Fichera, Senior Vice President of Transel was the applicant of record for this filing.

⁴ During the investigation, DOI obtained copies of recordings from 285 Madison Avenue’s security video surveillance system from the lobby and other floors. DOI’s review focused primarily on footage from the lobby and the 12th floor where Transel workers accessed the low-rise elevators in which they conducted work. It should be noted that 285 Madison Avenue’s security camera system was not time-accurately synchronized on the day of the incident from floor to floor and were different from floor to floor by approximately one minute. Therefore, the times noted herein are approximate and reflect the time stamp on each relevant video portion reviewed during the investigation.

⁵ The control panel computer chips are located in the motor room on the 14th floor. The motor room is a utility room that houses the elevator motors and control panels that operate the elevator. There are no security cameras in the 14th floor motor room.

7:44 a.m.: Transel Mechanic Michael Hill and Apprentice-Helper David O'Neill arrived at 285 Madison Avenue. Hill and O'Neill joined Cardona and Torzilli in performing governor recalibration of the low-rise elevators. To do so, Transel employees worked in the 14th floor control room and on each elevator cab being recalibrated.

8:10 a.m.: Cammisuli and Moran left 285 Madison Avenue. During interviews with DOI both of these employees stated that they left at this time because they completed the replacement of the elevator control panel computer chips in the 14th floor control room.

8:20 a.m.: O'Neill and Torzilli boarded the number 7 elevator car at the lobby floor and rode to the 12th floor (top floor for the low-rise elevator) where they exited. After exiting the elevator, O'Neill held the elevator doors open and communicated on a two-way radio. The video then appears to show the elevator descending. Interviews of O'Neill and Torzilli later confirm that the elevator was in fact descending at this time so that they could access the top of the cab. From that position, using a control on the roof of the cab, they switched the elevator from "automatic" to "inspection" mode, in effect keeping the elevator stationary while they recalibrated it. When the recalibration was complete, the controls were switched back to "automatic," which, in effect, returned the elevator into service. This process was repeated for each elevator the workers recalibrated. Subsequently, video footage shows O'Neill and Torzilli entering the number 7 elevator shaft.

8:57 a.m.: O'Neill and Torzilli emerged from the number 7 elevator shaft at the 12th floor landing.

8:58 a.m.: O'Neill and Torzilli placed an elevator hall call from the 12th floor, placed their tools to the side of the number 8 elevator door and then took an elevator car down to the lobby.

9:03 a.m.: O'Neill and Torzilli boarded the number 8 elevator car at the lobby floor and rode to the 12th floor where they exited. After exiting the elevator, O'Neill held the elevator doors open and communicated on a two-way radio. The video then appears to show the elevator descending. Interviews of O'Neill and Torzilli later confirm that the elevator was in fact descending at that time so that they could access the top of the cab. Subsequently, video footage shows O'Neill and Torzilli entering the number 8 elevator shaft.

9:22 a.m.: O'Neill and Torzilli emerged from the number 8 elevator shaft at the 12th floor landing, placed their tools to the side of the number 9 elevator door and placed an elevator hall call. Subsequently, they took an elevator car down to the lobby.

9:25 a.m.: O'Neill and Torzilli boarded the number 9 elevator car at the lobby floor and rode to the 12th floor where they exited. After exiting the elevator, O'Neill held the elevator doors open and communicated on a two-way radio. The video then appears to show the elevator descending. Interviews of O'Neill and Torzilli later confirm that the elevator was in fact descending at that time so that they could access the top of the cab. Subsequently, video footage shows O'Neill and Torzilli entering the number 9 elevator shaft.

9:54 a.m.: O'Neill and Torzilli emerged from the number 9 elevator shaft at the 12th floor landing and placed their tools to the side of the number 10 elevator door, made an elevator hall call and took an elevator car down to the lobby.

9:55 a.m.: O'Neill and Torzilli exited 285 Madison Avenue. It was later learned during interviews that they had completed their work on the number 9 elevator and had stepped out of the building to take a personal break.

9:56:11 a.m.: The number 9 elevator car hallway doors opened at the lobby, and the cab was empty.

9:56:35 a.m.: A female passenger entered the number 9 elevator car and pressed a call button.

9:56:45 a.m.: A male passenger entered the number 9 elevator car and pressed a call button.

9:56:46 a.m.: Ms. Hart is observed walking towards the number 9 elevator.

9:56:48 a.m.: Ms. Hart attempted to step into the number 9 elevator car, but the elevator cab began to rise with the doors open and struck her just below her knees.⁶ Ms. Hart lost her balance and partially fell into the number 9 elevator car as the elevator continued to rise up the elevator shaft.

III. Witness Testimony

On December 14, 2011, DOI and other agencies including DOB conducted preliminary interviews of the Transel employees who worked at 285 Madison Avenue on the day of the fatal elevator incident.⁷ During the course of these interviews, none of the Transel employees were able to explain what caused elevator 9 to move with the doors open after the car had been placed back into service. All of the employees were subsequently re-interviewed at DOI.

Michael Hill – Mechanic

On December 14, 2011, Hill was interviewed at 285 Madison Avenue at the incident scene. At this interview, Hill stated that at the time the incident occurred, elevator 9 was in full service because the upgrade work had been completed on that car. Hill also stated that he was not aware of any operational problems with elevator 9 prior to the incident and that he could not offer any explanation as to what caused elevator 9 to move with its car doors open.

On January 19, 2012, Hill was re-interviewed at DOI under oath. The following information was provided by Hill at his second interview:

⁶ If the number 9 elevator was still jumped at this time, meaning a bypass wire was used to override the safety circuits and allow the elevator to operate, the elevator would have started to rise because the two onboard passengers pressed destination floors.

⁷ On December 14, 2011, the following Transel employees who worked at 285 Madison Avenue on the day of the incident were interviewed: Michael Hill, Andrea Cammisuli, Efrain Cardona, Thomas Moran, David O'Neill, Robert Schroeder and Jason Torzilli.

Hill stated that he has been an employee of Transel for almost 12 years and has approximately 28 years of experience in the elevator industry.

Hill said that on December 14, 2011, O'Neill and Torzilli were working on one of the elevators on the 12th floor when O'Neill told him, via two-way radio, that O'Neill could not fit his arm between the hoist and cab doors to disengage the clutch, which is a mechanical door lock, nor could he successfully reach the door lock with his tomahawk tool.⁸ Hill stated that after receiving this radio communication, he bypassed the door lock from the 14th floor motor room control panel by using a long piece of wire found in the 14th floor motor room next to a spool of wire, a common procedure known as "jumping." Hill said that he placed a piece of wire, commonly referred to as a "jumper" wire, on two different points at the same time on the elevator control panel to bypass the elevator door locks so the helpers could gain access to the top of the elevator cabs.⁹

Hill added that the only time he had the bypass wire on the control panel was when he had to lower the elevator cars from the 12th floor to allow O'Neill and Torzilli access to the roof of the elevators. Hill explained that once the elevator is lowered, there is no reason to continue bypassing the circuit.

Hill was specifically asked whether he had accidentally left the "jumper" wire on the motor room control panel at the time of the fatal accident, and he replied that he had not. Hill stated that if the "jumping" wire had remained attached to the number 9 elevator control panel in the motor room, O'Neill and Torzilli would have observed the elevator move at the completion of their work, as they stepped off the top of the elevator and placed the car back in "automatic" mode.

Hill said that while working in the control room on the day of the incident he kept the "jumper" wire in his hand and never left it in the circuit board. Hill said he used the "jumper" wire to lower the elevator cabs and then removed the wire from the control panel once the lowering was complete. Specifically he stated, "The wire was in my hand, that wire was being used on each controller." Hill further stated that he did not observe or experience any errors or abnormalities while working in the motor room on December 14, 2011, and only became aware of the elevator incident after receiving a radio communication from O'Neill.

Hill said during his interview at DOI that he still had in his possession the "jumper" wire that he reportedly used at 285 Madison Avenue on the day of the incident. Following the interview, investigators accompanied Hill to a job site where he was then working and recovered what he said was the wire used at 285 Madison Ave. Hill provided DOI investigators with a green-covered wire approximately three feet long with a knot in the middle. The cover had been stripped away at both ends so that the wires were exposed. The stripped ends were straight and did not appear bent.¹⁰

⁸ A tomahawk tool is a hammer-shaped tool that allows a worker the ability to bypass an electrical circuit on the elevator cab.

⁹ During the course of the investigation it was determined that the use of a "jumper" wire is commonplace during maintenance and repairs and acceptable by industry standards and DOB regulations. However, according to DOB, in order to avoid an extremely unsafe condition, it is imperative that all "jumper" wires must be removed before an elevator is placed back into service.

¹⁰ According to DOB, a "jumper" wire which had been used to bypass a circuit on a control panel generally has a bent appearance after the wire has been attached to "set points" on an elevator control panel to bypass a circuit.

Efrain Cardona – Mechanic

Cardona was interviewed on December 14, 2011 at the incident scene and again at DOI on January 20, 2012. Cardona stated that he has been an employee of Transel for almost eight months and has approximately 28 years of experience in the elevator industry. Cardona said that on the date of the incident he was assigned to observe Hill's recalibration in the motor room.

Cardona stated that he was unaware that Hill utilized a bypass wire to allow any of the low-rise elevators to operate while the 12th floor hall doors were open. Cardona added that he observed Hill in front of the 14th floor motor room control panel communicating on a two-way radio, but could not specifically observe what Hill was doing. Cardona explained that Hill's back was to him and that he did not ask what Hill was doing because he was only there that day to observe work on the governor.¹¹ Cardona further stated that he is familiar with elevator control panel operations and did not see a need to ask questions.

Cardona said that immediately after the incident, he saw Hill on the two-way radio and overheard him say, "I'm not going to touch the controller until I know what's going on downstairs." They both then proceeded to the lobby.

Cardona informed DOI that Hill told him that on the day of the incident O'Neill tried to utilize the tomahawk tool, but for whatever reason could not, so Hill had to run the car down for them. Cardona stated that although Hill did not specifically say that he used a "jumper," based upon Cardona's understanding, the door lock system must be bypassed in order to operate the elevator from the control room.

Cardona said that he remembered observing Hill in the moments following the incident exiting the motor room with a long "jumper" wire in hand. Cardona described it as a foot long, stripped at both ends, shaped like a "U," green and taut.

Robert Schroeder - Mechanic

Schroeder was interviewed on December 14, 2011 at the incident scene and again at DOI on January 20, 2012. Schroeder stated that he has been an employee of Transel for almost nine years and has approximately 29 years of experience in the elevator industry.

Schroeder informed DOI that he is the assigned route mechanic for 285 Madison Avenue, which results in him visiting the building a couple of days a week to perform routine maintenance and that December 14, 2011 was one of those days. Schroeder stated that he arrived at the motor room at the time Hill and Cardona were working on the number 9 elevator governor; however, Schroeder stated that he did not participate in the governor recalibration.

Schroeder informed DOI that around the time of the elevator incident, in the 14th floor control room, he observed Hill receive an urgent call on the two-way radio but said he did not hear what was actually said. Schroeder said he subsequently exited the mechanical room with Hill and they made their way to the lobby.

Schroeder stated that he did not utilize a bypass wire in the motor room on December 14, 2011 and did not observe Hill or anyone utilizing a bypass wire. Nonetheless, Schroeder said that on the day

¹¹ The elevator 9 governor is located in the motor room several feet directly opposite the control panel.

of the incident, during their ride home, Hill told him that Hill had used a “jumper” wire to move the cars, but never said whether he had removed the wire prior to the elevator incident.

David O'Neill – Apprentice/Helper

O'Neill was interviewed on December 14, 2011 at the incident scene and again at DOI on January 20, 2012. O'Neill stated that he worked for Transel in 2009 for five or six months, was laid off due to lack of work, and was rehired in June 2011. O'Neill stated that he has approximately 11 years of experience in the elevator industry.

O'Neill stated that on the date of the incident he was assigned with Torzilli to perform work on the rooftops of all the low-rise elevators serviced that day. O'Neill said that to access the rooftop of the elevators, it is necessary to separate each elevator shaft's hallway door from the elevator's cab door via the clutch, and that on the first elevator he worked on he had a problem reaching the clutch because the space between the doors was narrow. O'Neill said that he informed Hill via a two-way radio and Hill responded that he would send the car down. O'Neill said that he had no knowledge of “jumpers” being used to lower any of the cars, but added that lowering the cars with “jumpers” is something that would have been done only via the control panel on the 14th floor. O'Neill stated that after the incident he never asked Hill how the elevator had been lowered. When asked, O'Neill said he did not observe elevator 9 move after he completed work on it and switched the car to “automatic.”

Jason Torzilli – Apprentice/Helper

Torzilli was interviewed on December 14, 2011 at the incident scene and again at DOI on January 20, 2012. Torzilli stated that he has been an employee of Transel for about a month and a half and has approximately nine years of experience in the elevator industry.

On the date of the incident, Torzilli was assigned with O'Neill to perform work on the rooftops of all the elevators. Torzilli said that O'Neill had difficulty separating the hallway door from the cab door because his arm couldn't fit between the doors. Torzilli was informed by O'Neill that Hill would therefore lower the elevator cars from the 14th floor motor room with the doors open. Torzilli stated that he did not know how Hill lowered the cars. When asked whether he had seen elevator 9 move after it was switched to “automatic,” Torzilli said he would not have been looking at the elevator at that time.

John Fichera – Elevator Agency Director/Owner of Transel

On February 2, 2012, Fichera was interviewed at DOI. Fichera stated that he has been the owner of Transel since 2000 and has been licensed by DOB as a Private Elevator Agency Director since approximately 1997. Fichera stated that Transel has approximately 150 employees and that his duties mainly include supervision and office work. In addition, Fichera said that he reviews all documents submitted to DOB before signing them, including applications to perform upgrades or significant repairs.

Fichera was not present at 285 Madison Avenue prior to fatal incident. However, during the interview, Fichera acknowledged that DOB should have been notified by Transel about the completion of elevator work at 285 Madison Avenue before the elevators were placed back in service. However, Fichera said that he only became aware after the fatality, when he reviewed the paperwork, that the type of work Transel performed that day required a call to DOB to give DOB the opportunity to inspect the work before the elevators were returned to service. Although Fichera was the applicant of record for the

job, and DOB holds him responsible for not notifying DOB of the completed elevator work, Fichera said that Transel's Maintenance and Repair unit had that responsibility.

IV. Wires Recovered from Motor Room

On December 22, 2011 at approximately 3:40 p.m., in the 14th floor motor control room of 285 Madison Avenue, DOI investigators and a DOB chief inspector observed two separate, eight-inch lengths of green-covered wire, which were stripped on all four ends, two of which were twisted together to form one wire of approximately 16 inches in length. The wires were observed under a metal grate floor within two feet of control panel number 9.¹²

V. Forensic Investigation of the Incident

On December 14, 2011, DOB responded to 285 Madison Avenue and commenced a forensic investigation of the cause of the fatal incident. The investigation was conducted by the DOB Elevator Division, with the assistance of DOB's Forensic Engineering Unit.¹³ In addition, DOB retained Lerch Bates, Inc. to assist in the forensic investigation of the incident.

In order to determine the cause of the incident, the investigation team simulated failures that could have caused the incident and compared those simulations with the building's security camera video recordings of the actual incident. The forensic investigation found that the only condition in which elevator number 9 could have moved during the incident is if the elevator was on "automatic" and the safety circuit was fully closed (by-passed). Based upon the evidence developed during the course of the investigation, DOB concluded that a portion of elevator number 9's safety circuit, most likely the car door and hoist way locks, were overridden by a "jumper" wire allowing the car to move with the doors open.

In the Lerch Bates report regarding the forensic investigation, the investigation team noted that local and national safety code standards for elevators, including the New York City Building Code, require the installation of safety devices designed to keep the public safe while riding in an elevator. According to Lerch Bates, one of the most critical of the devices is the "safety circuit." This circuit includes the "car door locks" and the "hoist way door locks" along with others. When this safety circuit is functioning normally and not compromised it does not allow the elevator to run if it is not completed or "made up." However, if this safety circuit is compromised by wire "jumpers," the mandatory safety features are disabled and the riding public is put in danger.

The Lerch Bates report further detailed that modern elevator controllers are designed with wiring terminal panels and mechanical connections points for key wiring circuits, including safety circuits. This design allows convenient installation of circuit wiring, but more importantly can provide a technician with a means to test circuit continuity. This design also allows technicians to place a clip wire "jumper" between terminals and close a circuit, providing a direct connection between two points. This "jumper" disables or "jumps out" any safety device included in the circuit. This trouble-shooting process can determine if an integral safety component has failed. However, if the wire "jumper" is left in place the required safety circuit is not functional and a potentially dangerous situation exists.

¹² According to DOB, the configuration and condition of the wires recovered from the grate immediately in front of the elevator 9 control panel are consistent with the type of "jumper" wires commonly used to bypass elevator safety circuits.

¹³ Chief Inspector Douglas Smith of the DOB Elevator Division was assigned as the Incident Commander for DOB. Assistant Commissioner Christopher Santulli of DOB's Forensic Engineering Unit also participated in the investigation.

Lerch Bates noted that during the initial startup of elevator car number 9 as part of the forensic examination, the car would not move until the safety circuit was fully closed. Due to the damage to the doors, the car doors and hoist way locks were “jumped out” to move the car. When these “jumpers” were removed, the car would not move. In addition, during the testing of several scenarios, including the testing of the speed feedback tachometer and the radio frequency interference testing, if the safety circuit was open and not “jumped” the car would not move.

Lerch Bates further stated that additional control errors were tested and none were found to match the conditions of the incident.

VI. DOB Enforcement Actions

On February 27, 2012, the Buildings Special Investigations Unit filed a petition seeking revocation of Fichera’s Private Agency Elevator Director license. Fichera filed a permit, called an Elevator Building Notice (“EBN”), to reduce the speed of elevators at 285 Madison Avenue. After this work was performed, Transel was required to notify DOB in order to obtain an inspection of these elevators prior to putting them back in service. Further, these elevators were not to be put back in service until DOB issued a “Certificate of Compliance.”

On December 14, 2011, work was performed on cars 7, 8, and 9 and these elevators were put back in service without first obtaining an inspection from the DOB. Had DOB been notified, car number 9 would not have been in service on December 14, 2011 until cleared by DOB. Other charges in this petition seeking revocation of Fichera’s license relate to wiring deficiencies, failure to place caution tape on the elevators and performing work without a permit. The violations were noted in 23 Environmental Control Board summonses issued by DOB.

VII. DOI Investigative Findings

DOI’s investigative findings, which are based on witness interviews among other evidence, support the conclusion of the forensic examination that the safety circuit of elevator 9 was apparently bypassed at the time of the fatal incident thereby allowing the car to move with its doors open when Hart attempted to step into the elevator cab. Specifically, the investigation found that:

Testimony taken by DOI established that Hill was assigned to work in the control room on the day of the fatality. Cardona testified that he saw Hill exiting the 14th floor motor room with a long “jumper” wire in his hand moments following the incident. Hill informed investigators that although he did use a “jumper” wire on several occasions to bypass the door locks on elevators 7, 8, and 9, it was not connected to the control panel at the time of the fatality.

Hill testified that the “jumper” wire was only on the circuit during the time O’Neill and Torzilli accessed the roof of elevator 9 and that he removed it before the fatal incident. Hill asserted that if he had not removed the jumper wire, O’Neill and Torzilli would have seen elevator number 9 move when they switched the elevator back to “automatic.” However, Torzilli testified that he was not looking at elevator 9 after it was switched to “automatic” mode by O’Neill. O’Neill testified that he did not observe elevator 9 move after he completed work and switched the car back to “automatic.” Video security footage shows that the elevator doors closed in less than six seconds after O’Neill and Torzilli are seen stepping out of the elevator, so if the elevator moved after that time it would not have been seen.

A review of the video security footage from the lobby at the time of the incident showed that moments before Hart attempted to enter elevator 9’s cab, the two onboard passengers had pressed

buttons for destination floors, thereby calling the elevator to a higher floor. The elevator started to rise with the doors open, which according to the DOB and its consultant, suggests that the door locks were bypassed by a “jumper” wire in place in the control room.

On December 22, 2011, DOI recovered a “jumper” wire in the 14th floor control room from beneath a grate that is immediately in front of elevator 9’s control panel. Subsequent to DOI’s recovery of the “jumper” wire from the control room, Hill, at his second interview on January 20, 2012, acknowledged for the first time having used a “jumper” wire on elevator 9 on the day of the incident. However, Hill said that he had used a different “jumper” wire that was still in his possession, which he later provided to DOI. Significantly, DOB’s opinion is that the wire found in the control room on December 22, 2011 had the physical characteristics of one that had been used in a manner consistent with “jumping” a circuit, while the wire produced by Hill on January 20, 2012, did not appear to have been used for that purpose.

According to the DOB, Transel failed to follow certain necessary safety procedures and protocols when its employees performed elevator work at 285 Madison Avenue. Those failures helped create the conditions that caused the fatal incident. Two specific unsafe conditions noted were that Transel failed to place caution tape inside the elevators and to call DOB prior to putting the elevators back in service. Had Transel notified DOB to perform an inspection prior to returning elevator 9 to service, as required by code, any “jump” wire that might have been in place, or any other significant problem, could have been discovered during the inspection process.

We are also referring our investigative findings to the New York County District Attorney’s Office for any action it deems appropriate. If you have any questions or wish to discuss this matter further, please contact Assistant Commissioner Michael Carroll (212) 825-3338.

Sincerely,

A handwritten signature in black ink, appearing to read "Rose Gill Hearn". The signature is fluid and cursive, with the first name "Rose" being more prominent.

Rose Gill Hearn
Commissioner